U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 04 October 2004

Case No. 2001-BLA-709

In the Matter of:

MANFORD J. HENLINE
Claimant

v.

ISLAND CREEK COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER ON REMAND - AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. A formal hearing was held before Administrative Law Judge Robert J. Lesnick on August 1, 2002, in Morgantown, West Virginia. On February 25, 2003, Judge Lesnick issued a Decision and Order - Awarding Benefits. The employer appealed to the Benefits Review Board, which issued a Decision and Order on February 25, 2004, vacating Judge Lesnick's decision in part, affirming it in part, and remanding the case to him for further proceeding. As Judge Lesnick is no longer with the Office of Administrative Law Judges, the case was assigned to me. The Board affirmed Judge Lesnick's finding that the x-ray evidence is insufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(1), but it also vacated his finding that the medical opinion evidence is sufficient to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4).

The Board remanded the case so that Judge Lesnick could: 1) reconsider whether the medical opinion evidence is sufficient to establish the existence of "legal" pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4), by addressing the comparative credentials of the respective physicians, the explanations of their conclusions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses; 2) consider the inconsistencies in the medical evidence and provide an explanation for my conclusions; 3) provide an explanation for what weight, if any, he accords the 1986 findings of the West Virginia Occupational Pneumoconiosis Board; and 4) weigh all the relevant evidence together under 20 C.F.R. § 718.202(a) pursuant to *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 22 BLR 2-162 (4th Cir. 2000). In addition, because he was told to reevaluate whether the evidence

is sufficient to establish the existence of pneumoconiosis and this analysis could also affect the weighing of the evidence on the issue of disability causation, the Board vacated Judge Lesnick's finding pursuant to 20 C.F.R. § 718.204(c).

The summary of medical evidence in Judge Lesnick's Decision and Order—Awarding Benefits issued February 25, 2003 is incorporated by reference; however, pertinent facts will be restated for clarity of discussion. First, the Board instructed him to reconsider whether the medical opinion evidence is sufficient to establish the existence of "legal" pneumoconiosis. It found that Judge Lesnick failed to explain why the opinions of Drs. Rasmussen and Cohen are better reasoned than the contrary opinions of Drs. Zaldivar, Renn, and Castle, and instructed him to give consideration to the physicians' qualifications, documentation underlying their medical opinions, and the sophistication and basis for their judgments.

Medical Reports

Dr. D.L. Rasmussen, who is board certified in internal medicine[1], examined the miner, took family, medical, and social histories, and performed objective tests consisting of a chest x-ray, pulmonary function study, and arterial blood gas study. (DX 11). Dr. Rasmussen diagnosed: 1) coal workers' pneumoconiosis based upon a twenty seven year coal mine employment history, and x-ray changes of pneumoconiosis; 2) COPD/emphysema based upon chronic productive cough, airflow obstruction, and reduced SBDLCO; and 3) possible asthma based upon the reversible airflow obstruction. Dr. Rasmussen attributed the miner's coal workers' pneumoconiosis to his coal mine dust exposure. He attributed the miner's emphysema to his coal mine dust exposure and his cigarette smoking history, and listed the etiology of the miner's asthma as "?". Dr. Rasmussen opined that the miner does not retain the pulmonary capacity to perform his last coal mine job, and he attributed the miner's disabling lung disease to the three cardiopulmonary risk factors of cigarette smoking, coal mine dust exposure, and possible asthma. In addition, Dr. Rasmussen concluded that it is medically reasonable to conclude that the miner has coal workers' pneumoconiosis that arose from his coal mine employment because he has a significant history of exposure to coal mine dust and has x-ray changes consistent with pneumoconiosis. The chest x-ray referred to in Dr. Rasmussen's report was read by Dr. Manu Patel, a dually-qualified physician. Dr. Rasmussen also concluded that the miner's coal mine dust exposure is a major contributing cause of his disabling respiratory disease, since his gas exchange impairment during exercise is significantly out of proportion to his ventilatory impairment.

Dr. George L. Zaldivar, who is board-certified in internal medicine, pulmonary disease, critical care medicine, and a B-reader, examined the miner on January 24, 2001. (EX 3, 4). In addition to a physical examination, Dr. Zaldivar reviewed the miner's medical records, including Dr. Rasmussen's report, noted the miner had about twenty seven years of coal mine employment, and smoked one half of a pack or more cigarettes per day for thirty four years. Dr. Zaldivar took a chest x-ray, which he interpreted as negative for pneumoconiosis, and performed pulmonary function and arterial blood gas studies. Dr. Zaldivar opined that: 1) there is no objective

[1] Dr. Rasmussen's credentials are not in the record; however, I take judicial notice that he is board-certified in internal medicine due to familiarity with his credentials from prior cases and a search of his credentials on the American Board of Medical Specialties website at <http://www.abms.org>.

evidence to justify a diagnosis of coal workers' pneumoconiosis or any dust disease of the lung; 2) there is a respiratory impairment present; 3) the impairment present both when Dr. Rasmussen examined the miner and when he examined him would prevent him from performing his usual coal mine work; 4) even if the miner were found to have coal workers' pneumoconiosis, his opinion regarding the cause of the pulmonary impairment would not change. Dr. Zaldivar also testified in a deposition taken on August 28, 2001. (EX 9).

Dr. Joseph J. Renn, III, examined the miner on July 17, 2001 and again on August 13, 2001. (EX 7). Dr. Renn is board-certified in internal medicine and pulmonary disease and a B-reader. (EX 8). Dr. Renn initially examined the miner for an independent medical evaluation, and then examined him again due to his suspicion of mild congestive heart failure on his initial exam. (EX 7). The miner was hospitalized with pneumonia on July 18, 2001, the day after Dr. Renn's initial exam. Dr. Renn recorded a cigarette smoking history consisting of one to one and one half packs per day for thirty two years and a coal mine employment history of approximately twenty four years. In addition to the physical exams, Dr. Renn recorded the miner's family and medical histories, and performed two chest x-rays, ventilatory and arterial blood gas studies, and an EKG. Dr. Renn diagnosed: 1) chronic bronchitis due to tobacco smoking with an 2) asthmatic component; 3) pulmonary emphysema due to tobacco smoking; 4) a pneumoconiosis does not exist; 5) moderate obstructive ventilatory defect with significant bronchoreversibility by ventilatory function studies; 6) arteriosclerotic coronary vascular disease; 7) old myocardial infarction; 8) systemic hypertension; 9) chronic congestive heart failure; 10) exogenous obesity; 11) allergic rhinitis and allergic conjunctivitis.

Dr. Renn stated within a reasonable degree of medical certainty that none of the diagnoses were either caused or contributed to by claimant's exposure to coal mine dust and the miner's chronic bronchitis with asthmatic component and pulmonary emphysema were caused by years of tobacco smoking, rather than exposure to coal mine dust. He further opined that it is with a reasonable degree of medical certainty that the miner is not totally and permanently impaired to the extent that he would be unable to perform his last coal mine employment or similar work. Dr. Renn also testified in a deposition on September 26, 2002. (EX 24).

Dr. James R. Castle, who is board-certified in internal medicine and pulmonary disease and is a B-reader, reviewed the medical evidence and issued a report dated November 19, 2001. (EX 10, 11). Dr. Castle opined that the miner does not suffer from coal workers' pneumoconiosis. Dr. Castle stated that the miner worked in or around underground coal mining for a sufficient period of time, and his exposure in his various positions was also sufficient to develop coal workers' pneumoconiosis if he were a susceptible host. He stated that another risk factor for his pulmonary symptoms or disease is his tobacco abuse history, which is sufficient to cause him to develop chronic obstructive pulmonary disease, i.e., chronic bronchitis emphysema, and/or lung cancer, and/or atherosclerotic vascular disease. Dr. Castle stated that the miner's third risk factor is asthma and he has a significant allergic history. He stated that the miner's fourth risk factor is his obesity which can result in shortness of breath on exertion. Dr. Castle stated that the miner did not have rales, crackles, or crepitations or findings indicating the presence of interstitial disease, and it was the opinion of the majority of radiologists and B-readers that there was no evidence of pneumoconiosis. Dr. Castle agreed with Dr. Zaldivar that the rapid development of hypoxemia between Drs. Rasmussen and Zaldivar's exams would

exclude coal workers' pneumoconiosis as an etiology for this event. He stated that for the above stated reasons, it is his opinion that the miner does not suffer from coal workers' pneumoconiosis.

Dr. Castle opined that the miner is most likely permanently and totally disabled as a result of his physiologic impairment which is due to tobacco smoke induced chronic airway obstruction with an asthmatic component and the development of an acute process such as bronchiolitis. He opined that the miner is also possibly disabled due to atherosclerotic cardiovascular disease and obesity. Finally, Dr. Castle stated that even if it were determined that miner has pneumoconiosis radiographically, his opinion concerning the lack of disability due to that process would remain unchanged. He stated that his opinion is not based on the miner having a negative x-ray, but is contingent upon his not having the physiologic changes indicating respiratory impairment due to that process.

Dr. Castle testified in a deposition on April 15, 2002. (EX 17). In addition, he issued two supplemental reports dated July 5, 2002 and July 30, 2002, after reviewing additional evidence. (EX 18, 23). In the first supplemental report, he stated that nothing in the new evidence makes him change his original opinion. In the second report, after he reviewed Dr. Cohen's opinion, he criticized Dr. Cohen's "confusing statements" pertaining to medical versus legal pneumoconiosis and their application to this case. He stated that nothing in the subsequent opinions causes him to change his previous opinions.

Dr. Robert A.C. Cohen reviewed the miner's medical records and issued a report dated July 11, 2002. (CX 13). Dr. Cohen is board-certified in internal medicine, pulmonary disease, critical care medicine, and is a B-reader. Dr. Cohen has also published extensively on occupational lung diseases, and is a consultant for the National Institutes of Health, the U.S. Mine Safety and Health Administration, the Black Lung Clinics Program for the Department of Health and Human Services, the United Mine Workers of America, the U.S. Agency for International Development, and is a course director for NIOSH certification in Spirometry. (CX 13). Dr. Cohen noted that the miner worked twenty four to twenty seven years as an underground coal miner and had at least a thirty two pack year cigarette smoking history ending in 1986. Dr. Cohen also reviewed the examination and consulting reports of Drs. Rasmussen, Renn, Zaldivar and Castle. Dr. Cohen opined that the miner suffers from coal workers' pneumoconiosis based upon his twenty plus years history of underground coal mine employment; his increasing symptoms of chronic lung disease, including cough, sputum production, shortness of breath, and wheezing; physical examination and treatment records consistent with chronic lung disease; worsening pulmonary function studies over time, which is consistent with his twenty two years of coal dust exposure and thirty two pack years of smoking; worsening cardiopulmonary exercise testing, x-ray evidence that, although conflicting, is positive for interstitial lung disease and pneumoconiosis, and the absence of any other occupational exposure.

Dr. Cohen opined that the pulmonary function tests confirm the miner has moderate obstructive lung disease with diffusion impairment, and this precludes him from engaging in the physical exertion of his coal mine employment. He stated that the miner's long-term exposure to coal dust was a significant contributory cause of his pulmonary disability, as manifested by his

obstructive defect and gas exchange abnormality. Dr. Cohen cited fifteen medical journal studies that confirm the link between coal mine dust exposure and obstructive lung disease, and that the correlation between dust exposure and respiratory symptoms "holds true even after controlling for smoking and age."

Re-evaluation of the Medical Opinion Evidence

The regulations define pneumoconiosis broadly as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. § 718.201. This definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* On remand, the Board required a determination of whether the medical opinion evidence is sufficient to establish the existence of "legal pneumoconiosis." Legal pneumoconiosis includes "any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." *Id.* There are five medical opinions in the record. Drs. Rasmussen and Cohen found that claimant has coal workers' pneumoconiosis and Drs. Zaldivar, Renn, and Castle opined that the miner does not have coal workers' pneumoconiosis.

Dr. Cohen, who is board-certified in internal medicine, pulmonary disease, critical care medicine, and a B-reader, considered the miner's underground coal mine employment of more than twenty years, thirty year cigarette smoking history, worsening symptoms of chronic lung disease, worsening pulmonary function studies over time, and absence of any other occupational exposure, and opined that the miner has moderate obstructive lung disease, which was significantly caused by both his coal mine dust exposure and his cigarette smoking. Dr. Cohen based his opinion on the objective evidence, including the conflicting x-ray evidence, the miner's physical symptoms and medical history, and his occupational and social histories. I consider Dr. Cohen's opinion to be well-documented and I also consider it to be very well reasoned. Of all of the physicians rendering opinions, with the exception of Dr. Rasmussen, only Dr. Cohen fully explained why he considered both the work and smoking histories as significant contributors to the miner's lung disease, and he provided citations to extensive medical journal research that the correlation between dust exposure and respiratory symptoms remains, even after controlling for age and smoking history. In addition, for every criticism directed to Dr. Cohen by the other physicians, Dr. Cohen provided credible and logical responses. Moreover, I note Dr. Cohen's substantial additional credentials and experience in the field of occupational lung disease. Therefore, I also find that he is the best qualified of the physicians rendering opinions in this case.

Dr. Rasmussen is board-certified in internal medicine. He concluded that the miner suffers from coal workers' pneumoconiosis based on his twenty seven years of coal mine employment and positive x-ray changes. In addition, Dr. Rasmussen diagnosed COPD and emphysema and, like Dr. Cohen, attributed it to both claimant's coal mine dust exposure and cigarette smoking history. Dr. Rasmussen also questioned whether the miner might also suffer from asthma. Dr. Rasmussen based his opinion on the objective studies, medical, occupational, and social histories, and a physical examination. Although Dr. Rasmussen is not as qualified as the other physicians because he is not a B-reader and is not certified in pulmonary medicine, I

still find that his opinion is well-documented and well-reasoned. I note that his opinion is consistent with Dr. Cohen's, who I found to be the most qualified of the physicians and whose opinion is the best supported by the medical records in evidence. Accordingly, I accord Dr. Rasmussen's opinion great weight.

Dr. Zaldivar, who is board-certified in internal medicine, pulmonary disease, critical care medicine, and a B-reader, opined that there is no objective evidence of coal workers' pneumoconiosis; there is a respiratory impairment present; and even if it were determined that the miner had coal workers' pneumoconiosis, his opinion regarding the etiology of the pulmonary impairment would not change. Dr. Zaldivar based his opinion on the objective studies, examination of the miner, and medical, occupational, and social histories. While I consider Dr. Zaldivar's opinion to be well-documented, I do not find it to be as well-reasoned as Dr. Cohen's or Dr. Rasmussen's opinions. Dr. Zaldivar relied on the partial reversibility seen on the miner's pulmonary function studies as the basis for excluding pneumoconiosis from his diagnosis. However, the restrictive disease process of clinical pneumoconiosis does not rule out other causes of the miner's obstructive lung disease or legal pneumoconiosis. Moreover, Dr. Zaldivar never explains why he did not consider the miner's lengthy underground exposure to coal dust as a significant factor in his pulmonary impairment. Accordingly, I find that Dr. Zaldivar's opinion is entitled to less weight because it does not entirely reflect the evidence in the record in relation to the miner's occupational history.

Dr. Renn diagnosed chronic bronchitis with an asthmatic component, pulmonary emphysema due to tobacco smoking, moderate obstructive ventilatory defect, arteriosclerotic coronary vascular disease, old myocardial infarction, systemic hypertension, chronic congestive heart failure, exogenous obesity, and allergic rhinitis and conjunctivitis. In addition, Dr. Renn opined that "a pneumoconiosis does not exist." Dr. Renn is board-certified in internal medicine, pulmonary disease, and is a B-reader. He based his opinion on two physical examinations, objective tests, and medical, occupational and social histories. Although Dr. Renn's opinion is well-documented, it is poorly reasoned and entitled to little weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

First, Dr. Renn acknowledged in his deposition that pneumoconiosis could have caused the abnormalities reflected in the miner's arterial blood gas results, that claimant's dyspnea is consistent with coal workers' pneumoconiosis, that the miner had enough coal dust exposure in his work history to develop pneumoconiosis "if he were a susceptible host," and that the miner's ventilatory studies neither rule out nor rule in pneumoconiosis because the pattern is not consistent throughout all of studies. Yet, Dr. Renn still diagnosed the miner with an obstructive defect due solely to smoking, without explaining why he ruled out the miner's occupational exposure in his diagnosis. It appears that Dr. Renn was focusing on the negative chest x-ray results when he stated that, "*a* pneumoconiosis" does not exist, which considers only the clinical definition of pneumoconiosis. In addition, there were inconsistencies in Dr. Renn's report pertaining to the miner's cardiac condition that are not supported by the rest of the medical records. As instructed by the Board, I considered and discussed these inconsistencies below. *See BRB Decision*, p. 8. For the above-stated reasons, I find that Dr. Renn's opinion is not well-reasoned.

Dr. Castle, who is board-certified in internal medicine and pulmonary disease, opined that the miner does not suffer from coal workers' pneumoconiosis but is disabled from a physiologic impairment which is due to tobacco smoke induced chronic airway obstruction with an asthmatic component, and development of an acute process such as bronchiolitis, and also possibly atherosclerotic cardiovascular disease and obesity. Dr. Castle stated that his opinion would not change even if the miner were found to have pneumoconiosis radiographically, and stated his opinion is based upon the miner not having the changes indicating respiratory impairment due to pneumoconiosis. Although Dr. Castle's opinion is well-documented it is not well-reasoned. Dr. Castle initially stated that the miner's coal mine employment was sufficient in both duration and level of exposure to develop coal workers' pneumoconiosis. Yet, Dr. Castle never explains why he rules out the miner's occupational exposure as a contributor to his chronic airway obstruction. He attributes his diagnosis to the lack of opacities on chest x-ray and explains that because the airway obstruction is without restriction, with minimal or no diffusion abnormality, he considers him to have asthmatic bronchitis. Additionally, Dr. Castle either appears not to understand, or rejects, the concept of "legal" pneumoconiosis and criticizes Dr. Cohen's application of its distinction from "medical," or clinical, pneumoconiosis to the miner's case. In addition to Dr. Cohen's cited research confirming the link between coal mine dust exposure and obstructive lung disease, the Board held that an obstructive impairment, without a restrictive component, may be considered regulatory pneumoconiosis. *Heavlin v. Consolidation Coal Co.*, 6 B.L.R. 1-1209 (1984). Moreover, the regulations provide that legal pneumoconiosis specifically includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. 20 C.F.R. § 718.201(a)(2) (2001).

In terms of the qualifications of the physicians rendering opinions, I find that Dr. Cohen is the most qualified with respect to both experience and published research, in addition to his board-certification and B-reader credentials. Drs. Zaldivar, Renn, and Castle are similarly qualified in terms of board-certification and B-reader credentials, but only Drs. Cohen and Zaldivar are also board-certified in critical care medicine. Although Dr. Castle also has the same credentials, his deposition testimony indicates that he is either not as up to date with the relevant research pertaining to medical and clinical pneumoconiosis, or does not appear to appreciate the distinction. In terms of board-certification and B-reader status, Dr. Rasmussen is not as credentialed as the other physicians. However, I take judicial notice of the fact that Dr. Rasmussen is well-qualified in terms of experience and published research.[2]

I find that not only is Dr. Cohen the most qualified physician, but also that his medical reports and testimony were better documented and reasoned than any of the contrary physicians. I also find that although Dr. Rasmussen does not possess board-certification in pulmonary disease and was not a B-reader at the time he examined the miner,[3] he is at least as qualified as the Drs. Zaldivar, Renn, and Castle in terms of published research on coal workers' pneumoconiosis. I find that Dr. Cohen's and Dr. Rasmussen's opinions— that the miner's occupational coal mine dust exposure and his cigarette smoking history both significantly

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[2] A search of medical journal articles on PubMed, a service of the National Library of Medicine, and Medline for "Rasmussen dl" returned ten medical journal articles authored by Dr. Rasmussen pertaining to coal workers' pneumoconiosis.

[3] I note that Dr. Rasmussen is currently a B-reader and is listed as of October 1, 2000. *See* U.S. Department of Health and Human Services, NIOSH approved B-reader list. Dr. Rasmussen examined the miner on August 7, 2000. (DX 11).

contributed to his chronic obstructive lung disease; i.e. "legal pneumoconiosis" —are better supported by all of the evidence in the record, including the miner's twenty one plus years of underground coal mine employment, worsening breathing problems, and cigarette smoking history. Because I find that these opinions are better reasoned, better supported, and entitled to more weight than those of the contrary physician opinions, I also find that they outweigh the less well-reasoned opinions of Drs. Zaldivar, Renn, and Castle. Accordingly, I find that the physician opinion evidence is sufficient to establish the existence of "legal" pneumoconiosis.

Next, I must consider the inconsistencies in the medical opinion evidence. *BRB Decision*, p. 8. Specifically, as I noted above, the medical reports conflict in relation to claimant's cardiac status. Dr. Renn recorded that the miner was hospitalized in 1981 with an acute myocardial infarction but he did not indicate where the miner was hospitalized. (EX 7). I reviewed the hospital records from both West Virginia University Hospital during 1980, and Webster County Memorial Hospital ranging from February 21, 2001 to July 2001, and I found no record of treatment for a myocardial infarction. (EX 12, CX 12). The WVU hospital records indicate that the miner underwent cardiac catheterization on November 3, 1980 but they ruled out coronary artery disease. (EX 12). In addition, the miner testified that he has never been treated for a myocardial infarction. (Tr. 26). None of the other physicians noted a myocardial infarction in the medical records.

Dr. Renn also stated in his opinion that claimant was hospitalized in May 2001 in Webster Springs Hospital for congestive heart failure, and that the miner suffered from "chronic congestive heart failure." (EX 7). I reviewed these records and the only reference to congestive heart failure was a discharge diagnosis summary dated February 21, 2001 signed by a Dr. Lauderman. It listed the discharge diagnoses as: 1) mild CHF, resolving; 2) acute exacerbation of COPD; 3) chronic pain syndrome; 4) GERD; 5) anxiety/panic disorder; 6) ASHD with hypertension; 7) allergic rhinitis. (CX 12). The only cardiac related records from May 2001 were two EKGs which were interpreted as normal and normal sinus rhythm. (CX 12). It is not clear from the records why these EKGs were taken. Subsequent Webster Memorial records from April 2001 indicate that the miner's CHF "had improved", although the discharge diagnosis from this visit was dyspnea. (CX 12). The Webster Memorial records from July 2001 note that the miner had "a bout with CHF" which appears to be referencing the February 21, 2001 discharge summary. Otherwise, there is nothing in the record that indicates the miner was suffering from "chronic" congestive heart failure, as diagnosed by Dr. Renn.

In addressing the inconsistencies in the medical records, I note that the reference to congestive heart failure in the February 2001 discharge summary was brief, and the records indicate that claimant was not treated for CHF, or diagnosed with it subsequently. I also note that none of the physicians except Dr. Renn recorded the presence of CHF, and that his discussion of it was not accurate because there is no evidence that it was ongoing or chronic. Moreover, Dr. Renn never explains how CHF would affect claimant's lung function to the degree that he would consider the miner's coal dust exposure to be inconsequential. Specifically, he also does not explain how the presence of CHF would necessarily rule out the presence of pneumoconiosis. Consequently, I do not find the absence of CHF from the other physicians' reports to be determinative, nor does it alter my conclusions about the medical opinions, because

its presence would not change whether the miner's exposure to coal mine dust contributed to his COPD.

I must now discuss the findings of the West Virginia Occupational Pneumoconiosis Board and provide an explanation for what weight, if any, I accord to its 1986 findings. The Board further instructed that in doing so, I must also address the credentials of the physicians preparing the report, the explanations for their conclusions, the documentation underlying their medical judgments, and the sophistication and bases for their diagnoses. *BRB Decision*, p. 9. According to the records, the State Board found "sufficient evidence to justify a diagnosis of 25% pulmonary functional impairment attributable to pneumoconiosis. (DX 8). This was based on a seventeen year exposure history. The State Board also relied upon the medical records from Tucker County Hospital, dated February 2, 1984 and Memorial Hospital dated May 30, 1985 and January 25, 1983. These reports are not in the record. Specifically, the State Board noted:

> [The Claimant] reports shortness of breath of six years duration, a chronic cough for 6 (sic) productive of yellow and (illegible) sputum [sic]. He has also worked in steel mills. He has had heart disease. Physical examination shows the claimant in fair general condition. He is not in any respiratory distress at rest. Mild increase in AP diameter of the chest and the breath sounds are suppressed, there are no rales or wheezing. Heart sounds are of good quality there are no murmurs. He was not given an exercise tolerance test because of the evidence of heart disease. X-ray interpretation: stereoscopic studies of the chest reveals a fine irregular type nodular fibrosis in moderate to slightly pertinent amount, the result of an occupational pneumoconiosis. (DX 8).

The physicians who signed the findings are Dr. James H. Walker (Chairman), Dr. William C. Revercomb, and Dr. J. Dennis Kugel. Their credentials are not in the record; however, a search of the U.S. Department of Health and Human Services, NIOSH approved B-reader list, reveals that Dr. Kugel has been a B-reader since 1970. In addition, a search of the physicians' credentials on the American Board of Medical Specialties website revealed that Dr. Walker is board-certified in thoracic surgery and Dr. Revercomb is board-certified in internal medicine. [4] Additionally, West Virginia law provides, in pertinent part, that "no person shall be appointed as a member of the board…who has not by special study, or experience, or both, acquired special knowledge of pulmonary diseases."[5] In addition, a quorum shall consist of any three members of the board and at least one member present must be a radiologist.[6]

> As Judge Lesnick noted in his Decision and Order:
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> The findings of the State Occupational Pneumoconiosis Board are not controlling in this claim, since the underlying statutes, regulations, and medical evidence are not identical. Moreover, in the present case, Claimant returned to the coal mines and continued to work many years thereafter. *ALJ Decision and Order dated February 25, 2003*, p. 11.

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4 <http://www.abms.org>.

5 West Virginia Statutes, Chapter 23, Article 4, Section 8(a).

6 *Id.*

In addition, the Benefits Review Board held that a state or other agency determination may be relevant, but is not binding upon the administrative law judge. *Schegan v. Waste & Management Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1987).

I take judicial notice, as set forth above, of the qualifications of the State Board physicians. I find that the State Board opinion is less well-reasoned than any of the physicians rendering opinions in connection with this claim. Like Judge Lesnick, I do not find the State Board findings to be controlling or entitled to much, if any, weight. I do, however, find the State Board's finding of a 25% pulmonary functional impairment due to pneumoconiosis to be relevant.

Finally, pursuant to *Compton, supra*, I must weigh all the relevant evidence together under 20 C.F.R. § 718.202(a). Judge Lesnick found that because the chest x-ray evidence neither ruled in, nor ruled out, the presence of pneumoconiosis, claimant had not met his burden of establishing pneumoconiosis by a preponderance of the chest x-ray evidence, pursuant to 20 C.F.R. § 718.202(a)(1). *ALJ Decision and Order* at 22. The Board affirmed this finding. *BRB Decision*, p. 6. In addition, there was no autopsy or biopsy evidence, and the presumptions set forth at 20 C.F.R. §§ 718.304,305, and 306 do not apply. *ALJ Decision and Order* at 22-23. I find that claimant established the existence of pneumoconiosis on the basis of the better reasoned medical opinions, pursuant to § 718.202(a)(4). I also find that although the findings of the West Virginia Occupational Pneumoconiosis Board are relevant to the miner's case, they are not controlling, and are entitled to less weight than the contrary medical opinions of record. Weighing all of the section 718.202(a) evidence together pursuant to *Compton*, I find that claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Although Judge Lesnick found that claimant did not establish pneumoconiosis based on a preponderance of the chest x-ray evidence, he also found that the x-ray evidence neither precluded nor established the presence of pneumoconiosis. This differs from a finding that the preponderance of the chest-x-ray evidence is negative for pneumoconiosis. Accordingly, since the chest x-ray evidence is inconclusive—as opposed to negative—for the presence of pneumoconiosis, I find that it does negate the weight of the medical opinion evidence that establishes legal pneumoconiosis. Therefore, weighing the chest x-ray evidence with the medical opinion evidence, I find that claimant has established the presence of pneumoconiosis pursuant to § 718.202(a).

Total Disability Due to Pneumoconiosis

Judge Lesnick's finding that the miner is totally disabled from a pulmonary standpoint was undisturbed. However, the Board also vacated Judge Lesnick's finding that claimant's totally disabling lung impairment is due to pneumoconiosis, because the reevaluation of the pneumoconiosis evidence could change the disability causation analysis. *BRB Decision and Order*, p. 9. Therefore, I must determine whether the miner's totally disabling respiratory impairment is caused by his pneumoconiosis.

Pursuant to 20 C.F.R. § 718.204(c)(1), a miner is considered totally disabled due to pneumoconiosis if the disease is a substantially contributing cause of his totally disabling

respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or if it materially worsens a totally disabling respiratory or pulmonary impairment that is caused by a disease or exposure unrelated to coal mine employment.

For the reasons set forth above in my reevaluation of the medical opinion evidence, I accord the opinions of Drs. Cohen and Rasmussen the most weight. The better reasoned medical opinions establish that the miner's coal mine dust exposure and his cigarette smoking history were both substantial contributors to his totally disabling respiratory impairment. Accordingly, I find that claimant's pneumoconiosis is a substantial contributing cause of his pulmonary disability pursuant to 20 C.F.R. § 718.204(c).

ORDER

IT IS ORDERED that Island Creek Coal Company:

(1) Pay claimant benefits, augmented by one dependent, beginning as of July 1, 2000;

(2) Reimburse the Black Lung Disability Trust Fund for interim payments made to claimant, if any, and

(3) Pay interest on unpaid benefits from the date thirty days after the initial determination of liability by the district director.

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DANIEL L. LELAND
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.